**W E L C O M E**

In order to facilitate your care, I have developed certain policies and procedures that I feel is important in establishing a working partnership. Please read this document carefully and initial each item to acknowledge your understanding and agreement. Your signature is required for treatment to commence. Thank you.

**APPOINTMENTS**

\_\_\_\_\_\_ You are expected to arrive for your appointment on time. Your time slot is reserved for you and only you, therefore you purchase your available time. If you are late, your session will still end at the same time.

\_\_\_\_\_\_ Please provide at least 24-hours to **CANCEL** appointments in order to avoid a late cancellation fee (fee will be the full session fee).

\_\_\_\_\_\_ Cancellations will be accepted via text or phone only. Requests for cancellation sent via email may not be seen and could result in a late cancel or no show fee.

**BILLING**

\_\_\_\_\_\_ All clients are billed per amount of session time scheduled. In case of late arrival and/or request for a reschedule within 24 hours of your appointment, you will still be billed for the full amount of time originally scheduled. **This cost is your responsibility.**

\_\_\_\_\_\_ All payments are due at the time services are rendered.

**MESSAGES/EMERGENCIES/AFTER HOUR CALLS**

\_\_\_\_\_\_ My services are outpatient only: Mondays, Wednesdays and Thursdays 10am-5pm. Outside of my office hours on those days, I strive to be as available as possible between the hours of 9:00am til 5:00pm on week days (M-F). I will respond to urgent messages within 24 hours.

\_\_\_\_\_\_ In case of emergency at any time, call 911 or proceed to the nearest emergency room; **do not await my callback**. Seek treatment via 911 or an emergency room and then please contact me from there.

\_\_\_\_\_\_ If a psychiatric hospitalization occurs, please notify me. Even if you have been told by hospital staff that we were informed, please take the time and call me yourself. This will help me better coordinate your care.

\_\_\_\_\_\_ Voicemail is checked regularly and all calls are returned to clients in order of clinical acuity. I will return messages within 24 hours.

\_\_\_\_\_\_ When you leave an **URGENT** message after 5:00 pm requiring a callback from me, I will provide consultation and support up to 10 minutes by phone at no charge. Beyond that, you will be charged a $25 fee for each 15 minute interval of time.

**POLICY CONCERNING CHILDREN**

\_\_\_\_\_\_ Please DO NOT leave your children unattended in the waiting room. If your child is age 12 and up they may quietly sit in the waiting room.

\_\_\_\_\_\_ Parent or Guardian MUST be present at the time of any child’s appointment, unless other arrangements are made in advance.

**MISCELLANEOUS**

\_\_\_\_\_\_ Please make sure your contact information is current and correct. It is your responsibility to notify us of any changes.

\_\_\_\_\_\_ If someone calls me to inquire about you and this person is not listed on your Release of Information form, **NO** information will be released, regardless of your relationship to this person. I will neither confirm nor deny that you are a patient.

***I hereby attend agree that I have read and understood the information provided to me regarding Policies and Procedures and I agree to abide by these terms and conditions.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Client or Parent/Guardian if Client is a Minor**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name**

**C L I E N T I N F O R M A T I O N**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If you go by another name list here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Identifying gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_ Zip\_\_\_\_\_\_\_\_**

**Are you okay with receiving mail? Y N**

**Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I take CIGNA insurance only. If you are using either of those for your sessions please provider your member ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you are not the sponsor on your plan please enter sponsor member ID, Date of Birth and Full name:**

**Sponsor ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sponsor DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sponsor Full name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Sponsor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sponsor address if not your mailing address above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Some other insurance plans will give you partial reimbursement for your sessions with me as I am a licensed provider. You would pay for the session at the time of the visit and then I would provide you with a superbill (by request) that you can submit to your insurance for partial reimbursement. Additionally, many people are able to use HSA’s (health saving account) for therapy and Flex spending accounts for therapy.**

**EMERGENCY CONTACT**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your major complaint today?:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you previously suffered from this complaint?:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Yes, for how long?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Yes, select previous treatment(s).**

\_\_\_Counseling: If yes, please see below for additional information.

-Add’l: When? \_\_\_\_\_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_ Good experience? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Medical (Psychiatric) Doctor: Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Medication: Currently prescribed medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-Previously prescribed medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Dietary Changes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If yes for previous Counseling treatment, please provide additional info:**

With Whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When? \_\_\_\_\_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_

Good experience? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment Outcome? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional previous Counseling treatment, please provide additional info:**

With Whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When? \_\_\_\_\_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_

Good experience? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment Outcome? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous mental health diagnosis**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Aggravating Factors- What makes this worse?**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relieving Factors- What makes this better?**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Present Situation**

**Primary Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **For how long?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you in a committed relationship?**

\_\_\_Single \_\_\_Married/Engaged \_\_\_Dating \_\_\_Widowed \_\_\_Divorced \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_

**How long have you been in this relationship?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Partner’s First Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How would you generally describe your relationship with your partner?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Widowed, how long were you together**\_\_\_\_\_\_\_\_\_\_ **When did your partner pass away?** \_\_\_\_\_\_\_\_\_\_

**Prior marriages from divorce?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your sexual orientation?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you sexually active?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Children? Names and ages** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**History of Infertility? Brief details:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Grief History. Who died/when/circumstances?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Symptoms**

(check all that apply)

\_\_\_Anger

\_\_\_Anxiety
\_\_\_Appetite Changes
\_\_\_Attention or concentration difficulties

\_\_\_ Avoidance

\_\_\_Compulsive behaviors (feeling you HAVE to do something, ie. hand washing, checking doors/locks,etc) \_\_\_Computer/phone/video game excessiveness
\_\_\_Crying Spells
\_\_\_Depression
\_\_\_Excessive Energy
\_\_\_Fatigue
\_\_\_Financial Stress
\_\_\_Flashbacks
\_\_\_Gambling, problematic
\_\_\_Grief

\_\_\_Guilt
\_\_\_Hallucinations (seeing/ hearing things others don't)

\_\_\_Delusions (believing things others don't tend to believe)

\_\_\_Eating: Binging/Purging food (excessive intake and/or vomiting after eating)
\_\_\_Eating: Emotional Eating (eating to numb/cope with stress and/or pain)

\_\_\_Eating: Restricting food

\_\_\_Impulsivity
\_\_\_Infidelity
\_\_\_Insomnia

\_\_\_Irritability
\_\_\_ Intrusive thoughts

\_\_\_Legal issues
\_\_\_Libido Changes Increase or decrease (circle)
\_\_\_Loss of Interest or Motivation
\_\_\_Nightmares
\_\_\_Panic Attacks (How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
\_\_\_Pornography
\_\_\_Racing Thoughts
\_\_\_Risky Activity
\_\_\_Self-injury
\_\_\_Shame

\_\_\_Shopping, excessive
\_\_\_Sleep Changes
\_\_\_Substance Addiction (smoking, caffeine, pain killers, alcohol, street drugs)
\_\_\_Past Suicidal attempts

Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Suicidal Thoughts

Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

**Primary Care Physician Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What medications are you currently prescribed? By whom? Dosage ? To treat what condition?:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Other medical conditions**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Have you ever been tested for or diagnosed with** (please include details):

**A Thyroid Disorder**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attention Deficit Hyperactive Disorder?** **Are you taking medication for this?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever suffered a head injury** (ie. concussion, car accident, hard fall off a bike, football?):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

**Were you adopted**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **If yes, at what age**?:\_\_\_\_\_\_\_

**Is your mother still living**? \_\_\_\_\_\_ **If not, when did she die**?:
\_\_\_\_\_\_\_\_

**Is your father still living**? \_\_\_\_\_\_ **If not, when did he die**?:
 \_\_\_\_\_\_

**Siblings and their ages**:
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are your parents married ( if both living)? If not, what's the marital status of any living parent?:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Were there any significant traumas or losses in your childhood (including physical/emotional/sexual abuse, loss of a loved one or caregiver, difficult moves or loss of friends, etc):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever tried the following?** (check all that apply)

\_\_\_Tobacco
\_\_\_Marijuanna

\_\_\_Hallucinogens (LSD)

\_\_\_Heroin

\_\_\_Methamphetamines

\_\_\_Cocaine
\_\_\_Stimulants (Pills)

\_\_\_Ecstasy

\_\_\_Methadone

\_\_\_Tranquilizers
\_\_\_Pain Killers

**If yes to any, list frequency, quantity and last dates of use:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been treated for drug/alcohol abuse? If yes, when?:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you smoke cigarettes? If yes, how many per day?:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you drink caffeinated beverages? If yes, how many per day?:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever abused prescription drugs? If yes, which ones?:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been arrested? If yes, when and why?:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional**

**Anything else you want me to know?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Client or Parent/Guardian if Client is a Minor**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name**

**T R E A T M E N T R A T E S & P A Y M E N T P O L I C Y**

* Payment is expected at the time of each session.
* I accept cash, checks and credit cards as payment. Returned checks will be subject to a $40 fee.
* Clients will be responsible for the full session fee for any no shows or late cancelled appointments made inside of 24 hours.
* I require payment for the following additional services.
* Telephone consultation: after 10 minutes at no charge, consultation and support will be charged a $25 fee for each 15 minute interval of time
* Completion of disability forms and other forms of written communication are billed in 15 minute increments at $150 per hour.
* Legal consultation – report writing, correspondence and telephone contact for legal actions are billed at $200 per hour
* Payment in full is requested prior to releasing any prepared letters, reports or documents in regards to any of the above services.

Please sign this policy statement prior to your treatment with Anne Cleary, LMHC, to indicate that you understand and accept these payment policies.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Client Date**

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**Signature of Client or Parent/Guardian (if client is under age 18) Date**

**R E L E A S E O F I N F O R M A T I O N A N D C O M M U N I C A T I O N**

Client’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Anne Cleary, LMHC, to release and/or request information related to the care of the above-named client with:

 **Person/Organization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Information to be disclosed (please check all that apply)

\_\_\_\_ Assessment and Diagnosis \_\_\_ Academic/Educational Information

\_\_\_ Treatment Progress and Goals \_\_\_ Consultations, Evaluations and Reports

\_\_\_ Medication Management \_\_\_ Other: Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The purpose of this disclosure of information is to improve assessment/treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

My privacy is protected under Federal Law, Federal Confidentiality Regulations (42 CFR, Part 2) prohibits information contained in my record to be disclosed without consent unless otherwise provided for in the regulations.

I understand that I have a right to revoke this authorization at any time upon written request; otherwise this consent will expire in one year. I further understand that a revocation of this authorization is not effective to the extent that action has been taken in reliance on the authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Client Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Client or Parent/Guardian (if client is under age 18) Date**

**I N F O R M E D C O N S E N T F O R P S Y C H O T H E R A P Y**

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me.

**THE THERAPEUTIC PROCESS**

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself. With perseverance, openness, and practice of new skills, most clients experience an improved ability to accept and interact more positively with the world around them. At times I will challenge you which is part of the growth process.

**CONFIDENTIALITY**

The session content and all relevant materials to the client’s treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below and further detailed in the Notice of Privacy Practices:

1. If a client threatens or attempts to attempt suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.

2. If a client threatens grave bodily harm or death to another person.

3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.

4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.

5. Suspected neglect of the parties named in items #3 and # 4.

6. If a court of law issues a legitimate subpoena for information stated on the subpoena.

7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert’s report to an attorney.

8. If the therapist is unexpectedly incapacitated and unavailable to reschedule appointments, another trusted individual may contact you to make arrangements.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

In couples therapy, I have a "no secrets" policy which I will discuss our first session. In brief, it means that while I'll typically hold confidential what may be shared with me in an occasional individual session (subject to the above limitations), I will not be a "secret holder." If such information (ie. such as an addiction, affair, etc) is divulged, I will work with that partner to share the information with the spouse. If the partner is unwilling, I will need to terminate therapy as these issues will prevent reaching the agreed upon goals of relationship improvement.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

**APPOINTMENTS/CANCELLATIONS**

Appointments are generally 50 minutes in length, with EMDR sessions typically 80-85 minutes, typically weekly in the beginning and tapering as we make progress toward your goals. Often new behaviors are recommended for practice between sessions, as is reading on particular topics. Appointments are scheduled first-come, first-serve, although I do allow scheduling out 2 appointments in advance.

**Cancellations/reschedule requests are needed 24 hours in advance to avoid a full session fee**. Once scheduled, that time is reserved just for you so please make it a priority on your schedule as it is on mine.

Regular rescheduling will be addressed as a clinical issue. 2 missed appointments without communication will result in my concluding you have terminated therapy. Final charges will be billed to you.

USE OF DIAGNOSIS

Payment for services is due at the time of the appointment. You will receive a "superbill" receipt with information that is necessary for insurance submission should you choose to file for any available benefits. You should be aware that in order to receive benefits, I must apply a diagnosis that the insurance considers “medically necessary.” Once filed, they may request at any time for medical records to support the necessity of treatment. It would be your decision to authorize release of that clinical information or not. Be aware that mental health information submitted to your insurer becomes part of your permanent health record and is available to various entities such as life insurance underwriters and perhaps some employers.

**SAFETY/ NO WEAPONS**

For the safety of you, me, and other clients that may be in the office, we take all safety issues seriously and strive to take all preventive actions. To this end, there is a **NO WEAPONS POLICY**. Please leave any guns, knives, pepper spray or the like at home or in the car. If during session I perceive that you are emotionally unstable to drive yourself home or at risk of harm (refer to Confidentiality #1-2 above), I may call a friend/family member to come assist you home or in severe cases, need to call 911 for paramedic assistance.

***By signing below, I agree to the terms of this Informed Consent. My typed signature is legally binding.***

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**Signature of Client Date**

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**Signature of Client or Parent/Guardian (if client is under age 18) Date**

FINANCIAL AGREEMENT

I have read and understand the information regarding fees and payment. I understand and agree to this payment contract. I understand that I am responsible for my fee and that fees are due at the time of service. Please be advised that if a balance accumulates on your account and no effort is made on your part to pay the balance in a timely manner, I reserve the right to turn your account over to a collection agency and to terminate services/treatment immediately.

 \_\_\_\_\_\_\_ I agree to pay $\_\_\_\_\_ per hour. If you need to cancel without at least 24 hours notice you will be charged for the full session. My valid credit card information is:

Credit Card: VISA MASTERCARD AMERICAN EXPRESS DISCOVER (circle one)

Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CDC code on back \_\_\_\_\_

Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client(s) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_